SERFF Tracking Number:	*AULD-127685512*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49971*
Company Tracking Number:	*G-23223-EOI*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Filing at a Glance

Company: American United Life Insurance Company

Product Name: Statement of Insurability	SERFF Tr Num: AULD-127685512	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49971
Sub-TOI: L08.000 Life - Other	Co Tr Num: G-23223-EOI	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Bridget McGill, Angie Neville, Danita Ragland-Hatton	Disposition Date: 10/10/2011
	Date Submitted: 10/06/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: This form was filed in Indiana, our domiciliary state, on September 30, 2011.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 10/10/2011
	State Status Changed: 10/10/2011
Deemer Date:	Created By: Angie Neville
Submitted By: Angie Neville	Corresponding Filing Tracking Number:
Filing Description:	

October 6, 2011

Re: American United Life Insurance Company - NAIC #60895
Application for Life Insurance, G-23223
Statement of Insurability, G-23223-EOI
Forms to be used with Individual Life Insurance and with Group Life and Disability Income Insurance as explained below

SERFF Tracking Number:	*AULD-127685512*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49971*
Company Tracking Number:	*G-23223-EOI*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Dear Department of Insurance:

Attached for approval are the above-referenced forms. These forms are new and do not replace any existing forms on file with your Department. The Application for Life Insurance, G-23223, will be used to apply for individual life insurance. The Statement of Insurability, G-23223, may be used when applying for the following products on file with your department: (1) individual life insurance; (2) group term life insurance; and (3) group disability insurance. The Statement of Insurability form was filed in our domiciliary state, Indiana, on September 30, 2011, and is pending approval. We are filing under life and disability separately. The Disability SERFF tracking number is AULD-127685909.

The Application for Life Insurance, G-23223, will be used to apply for individual life insurance coverage with American United Life Insurance Company (AUL). The target market is employees whose employers have group insurance with AUL.

This Statement of Insurability, G-23223-EOI, will be used at enrollment to medically underwrite individuals who apply for:
·Individual life insurance coverage;
·An amount of group term life insurance coverage or group disability income insurance coverage above the Guaranteed Issue Amount;
·Group term life insurance coverage or group disability income insurance coverage as a Late Enrollee; or
·A change in group term life insurance coverage or group disability income insurance coverage if the policy requires the completion of evidence of insurability.

So the employee does not have to answer underwriting questions twice, once with the life insurance application and then again, where appropriate, when enrolling for group coverage, the Statement of Insurability form will be used to medically underwrite for both the individual life insurance and if applicable, for the group insurance products as listed above.

Variable language has been marked with brackets which generally indicate optional benefits or provisions. If the language is changed, it will never be less favorable than your state's laws allow.

Please acknowledge approval of these forms via SERFF.

You may call me at 317-285-1809 or contact me by e-mail at productcompliance.corporatecompliance@oneamerica.com if you have any questions. Thank you for your assistance with this filing.

Sincerely,

Bridget McGill

SERFF Tracking Number:	*AULD-127685512*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49971*
Company Tracking Number:	*G-23223-EOI*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Senior Contract Analyst
Corporate Compliance and Market Conduct

Company and Contact

Filing Contact Information

Bridget McGill, Sr. Contract Analyst
One American Square
Indianapolis, IN 46206

Bridget.McGill@oneamerica.com
317-285-1809 [Phone]

Filing Company Information

American United Life Insurance Company
One American Square
P.O. Box 7127
Indianapolis, IN 46206
(877) 285-7660 ext. [Phone]

CoCode: 60895
Group Code: 619
Group Name:
FEIN Number: 35-0145825

State of Domicile: Indiana
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American United Life Insurance Company	$100.00	10/06/2011	52561980

SERFF Tracking Number:	*AULD-127685512*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49971*
Company Tracking Number:	*G-23223-EOI*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/10/2011	10/10/2011

SERFF Tracking Number:	*AULD-127685512*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49971*
Company Tracking Number:	*G-23223-EOI*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/10/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AULD-127685512*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49971*
Company Tracking Number:	*G-23223-EOI*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Statement of Variables - EOI		Yes
Supporting Document	Statement of Variables - Application		Yes
Form	Statement of Insurability		Yes
Form	Application for Life		Yes

SERFF Tracking Number:	*AULD-127685512*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49971*
Company Tracking Number:	*G-23223-EOI*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: G-23223-EOI

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	G-23223-EOI	Application/ Enrollment Form	Statement of Insurability	Initial		50.200	G-23223-EOI.pdf
	G-23223	Application/ Enrollment Form	Application for Life	Initial		54.000	G-23223.pdf

Statement of Insurability

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
1-800-553-5318

ONEAMERICA®

Section A: Proposed Insured *(complete Statement of Insurability)*

Proposed Insured Name: ____________________

Driver's License Number ____________ State where Issued ____________

Height ______ ft. ______ in. Weight ______ lbs. ☐ Gained ☐ Lost ______ lbs. In Past Year

Spouse and/or Child(ren) must complete Statement of Insurability if required for Group Coverage.
Whole Life Insurance Coverage not available for Spouse/Children.

Spouse/Partner Name *(Last, First, Middle)* — Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Driver's License # ______ State where Issued ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)* — Relationship to You ______ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)* — Relationship to You ______ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)* — Relationship to You ______ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)* — Relationship to You ______ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Underwriting Information

Section B: Health Questions

1. Within the past 7 years, has any applicant for insurance been diagnosed or treated by a physician or medical professional, tested positive for the presence of, or taken prescribed medicine for the following: ***(Circle conditions that apply in multi-condition questions, and provide full details to any "yes" response in Section 4.)***

	Proposed Insured	Spouse	Children
a. Cancer, malignancy, or tumor of any kind?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Diabetes, thyroid, or other glandular disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Chest pain, angina, or heart attack; heart disease/disorder or murmur, peripheral vascular disease, elevated cholesterol or triglycerides?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. High blood pressure or hypertension?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Anemia, bleeding disorder, clotting disorder or other blood disease or disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Neurological or brain disorder, seizures, epilepsy, paralysis, multiple sclerosis, ALS or Lou Gehrig's disease, Parkinson's disease, Alzheimer's, other forms of dementia/cognitive disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Stomach or intestinal disorder, Crohn's, irritable bowel disorder, diverticulitis, GERD/reflux?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Stroke or transient ischemic attack (TIA)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Kidney, urinary bladder, gallbladder, pancreas, liver disorder or hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. Psychological, psychiatric, or emotional disorder, depression, anxiety, stress?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. Lung or respiratory disorder/disease, shortness of breath, asthma?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l. Neuromuscular, musculoskeletal disorders, lupus, arthritis, neck-, back-, knee- or foot disorders, other joint disorder, fibromyalgia, or chronic fatigue syndrome?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m. Skin or lymph node disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n. Eye, ear, nose, mouth, or throat disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or any immune deficiency related disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p. Prostate or testicular disorder, female reproductive organ disorder, or sexually transmitted disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section B: Health Questions *(continued)*

2. Within the past 5 years, has any applicant for insurance: ***(Circle information that applies in multi-part questions, and provide full details to any "yes" response in Section 4.)***

	Proposed Insured	Spouse	Children
a. Had a checkup or consultation with a physician or medical practitioner?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Been an inpatient or outpatient in a hospital, clinic, or medical facility or any similar entity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Taken in the past, or is currently taking, any prescription medicine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. Had an EKG, x-ray, blood study, urinalysis, treadmill, heart cath, MRI, CT scan, biopsy, or any other diagnostic testing?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Made a claim or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition, and/or been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Received or been instructed to seek treatment for use or abuse of: ☐ Alcohol ☐ Drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates, inhalants, or any other habit-forming drug or substance, whether prescribed or non-prescribed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Had any surgical procedure for weight loss? If so what was date of surgery? _____ What was your pre-surgery weight? _____ lbs.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. Been rejected, declined, rated, postponed, or modified for life or disability insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. Had any illness, disease, injury, operation, or treatment other than stated above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. Currently, is any Applicant: ***(Provide details to any "yes" response in Section 4.)***

a. Pregnant? Expected delivery date: _____ *(List current or past complications or high risk issues, including but not limited to pregnancy related high blood pressure, diabetes multiple gestations, i.e., twins, etc in Section 4.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Has any applicant ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products? If Yes, provide detail below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name _____

1. ☐ Present ☐ Former
2. Type of nicotine or tobacco used: _____
3. When did the applicant quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year

If more than one applicant has used nicotine, provide full details in Section 4.

4. Describe details of each "yes" response from Questions 1-3. If needed, use separate sheet of paper.

Name	*Question No.*	*Details of injury, illness, or disorder*	*Date*	*Name of Physician, Hospital, or Other Provider*

Authorization and Acknowledgement

I/we authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about me (and my spouse and/or my dependents, if they are to be insured): facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. **This authorization does not authorize the release of genetic screening or testing results.** All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date shown below. In Arizona, this authorization is limited to 180-days for disclosure of HIV-related information. I/we understand that any person requesting to be insured may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made, I/we can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my/our knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) I/we certify that all notices contained herein were read and understood prior to my/our completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgment.

Signatures

Signature of Proposed Insured / Employee *Mo. / Day / Year*

Printed Name of Proposed Insured / Employee

Signature of Spouse / Partner *Mo. / Day / Year*

Printed Name of Spouse / Partner

Signature of Dependent Child Age 18+ *Mo. / Day / Year*

Printed Name of Dependent Child Age 18+

Application for Life Insurance

(Please print in dark ink.)

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 6003
Indianapolis, IN 46206-6003
For general inquiries call: 1-800-553-5318

OneAmerica®

General Information

Group Name _____ Group Number _____

1. Proposed Insured (Please print and give full name.)

First Name *Middle Initial* *Last Name*

Street Address _____

City *State* *Zip* *County*

☐ Male ☐ Female Birthdate _____ Place of Birth _____

Work Phone Number _____ Home Phone Number _____

Cell Phone Number _____

Social Security Number _____ E-mail Address _____

Are you legally authorized to work and reside in the United States? ☐ Yes ☐ No

Occupation _____

2. Proposed Insured's Beneficiary for the Legacy Whole Life Insurance

Unless otherwise directed, the insurance proceeds shall be divided equally among all persons who are named as primary beneficiary and who survive the insured, but if none survive, equally among all persons who are named as secondary beneficiary and who survive the insured.

Primary Beneficiary

Full Name *Relationship to Insured* *SSN* *DOB*

Street Address *City* *State* *Zip*

Secondary Beneficiary *(if no primary beneficiary is living)*

Full Name *Relationship to Insured* *SSN* *DOB*

Street Address *City* *State* *Zip*

Please Note: If additional Beneficiary information is necessary, attach that information to this form.

3. Insurance on Proposed Insured

Legacy Whole Life Insurance with Waiver of Premium for Disability Benefit

Face Amount of Whole Life Insurance Policy $_____

Term Rider $_____ Guaranteed Period _____

Total $_____*

**Any combination of Whole Life and Term, 4 units maximum. (One unit equals $25,000.)*

4. Nonforfeiture Information

☐ Automatic Premium Loan *(if available)* ☐ Yes ☐ No *(If not completed, APL will be applied if applicable)*

5. Information Regarding other Coverage

a. Do you have existing life insurance or annuity(ies) with this or any other company? ☐ Yes ☐ No

b. Will this policy be replacing or changing any existing life insurance or annuity with this or any other company?
☐ Yes ☐ No If yes, provide details below.

c. List all life insurance or annuities in force on Proposed Insured:

				Replacement?	
Amount	Issue Year	Type	Company / Policy No.	No	Yes

Fraud Notices

- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- **Louisiana and Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- **Maine:** Any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties may include imprisonment, fines or denial of insurance benefits.
- **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance or knowingly and willfully fails to provide material information in connection with person's eligibility or continued eligibility for benefits under a disability insurance policy, is guilty of a crime and may be subject to fines and imprisonment.
- **New Jersey:** Any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties.
- **New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
- **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against in insurer, submits an application or files claim containing a false or deceptive statement is guilty of insurance fraud.
- **Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **Tennessee, Virgina and Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Agreements

I represent that I have read and understand all the statements and answers given in this application and Statement of Insurability and that they are true and complete to the best of my knowledge and belief. It is agreed that:

a. the statements and answers given to this application and any amendments to it will be the basis of any insurance issued;
b. no representative has the authority to make or alter any contract for the company;
c. the company may indicate changes in an endorsement to this application for administrative purposes only, and I must agree in writing to any other changes in this application;
d. no whole life insurance coverage will take effect until AUL approves this application and the full first premium is paid.

I certify that I have read, or had read to me, the completed application and I realize that any false statement or misrepresentation therein may result in loss of coverage under the policy.

I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.

Acknowledgement

This section must be completed by the proposed policy owner.

PLEASE MARKTHE FOLLOWING BOX, IF APPLICABLE

☐ I acknowledge that an illustration conforming to the whole life policy applied for was ***not*** provided. I understand that I may request an illustration conforming to the whole life policy as issued.

Substitute W-9 Certification

I certify, under penalty of perjury that 1) the number shown on this form is my correct taxpayer identification number, or I am waiting for a number to be issued to me; and 2) I am not subject to backup withholding because: a) I am exempt from backup withholding or b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding; and (3) I am a U.S. citizen or other U.S. person (as defined in Form W-9 located at www.irs.gov).

☐ **Check this box if you have been notified by the IRS that you are currently subject to withholding because of under reporting interest or dividends on your tax return.**

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATION REQUIRED TO AVOID BACKUP WITHHOLDING.

Signatures

Signed at: _____ on _____ (mm/dd/yyyy)
City, State *Date*

Proposed Insured _____ _____
Printed Name *Signature*

Witness _____ _____
Printed Name *Signature*

SERFF Tracking Number:	*AULD-127685512*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49971*
Company Tracking Number:	*G-23223-EOI*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachments:
Standard Cert of Compliance _Blank_.pdf
READCERT.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: N/A
Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variables - EOI
Comments:
Attachment:
Statement of Variables - G-23223-EOI.pdf

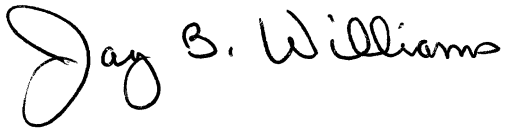
Item Status: **Status Date:**

Satisfied - Item: Statement of Variables - Application
Comments:
Attachment:
Statement of Variables - G-23223.pdf

CERTIFICATE OF COMPLIANCE

State of Arkansas

I, Jay B. Williams, Vice President Chief Compliance Officer, of the AMERICAN UNITED LIFE INSURANCE COMPANY®, hereby certify that the enclosed Forms comply with all Insurance Statutes, Regulations, and Departmental requirements of the State of Arkansas.



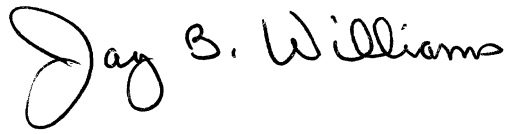
Jay B. Williams
Vice President Chief Compliance Officer

Date: October 6, 2011

CERTIFICATE OF READABILITY

I, Jay B. Williams, Vice President and Director of Compliance of American United Life Insurance Company, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements.

FORMS	READABILITY SCORE
G-23223-EOI	50.2
G-23223	54.0



October 6, 2011

Jay B. Williams
Vice President and Director of Compliance

STATEMENT OF VARIABLES
G-23223-EOI

FORM NUMBER	SECTION TITLE	PROVISION/ DESCRIPTION	BRACKETED VARIABLES EXPLANATION
G-23223-EOI	Statement of Insurability	Company address/phone number	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
"	"	OneAmerica (logo)	Bracketed for ease in updating the logo in case it is changed.
"	Section A	Spouse and children	Bracketed so the spouse and children questions may be deleted if evidence of insurability information for spouse and children are not applicable. Bracketed for ease in updating as need arises whenever there is a change in product(s) offered to the spouse and children– the change could be in a product name or it could be a new product that has been filed and approved by the state
"	Section B	Spouse and Children columns	Bracketed so the spouse and children area may be deleted if evidence of insurability for spouse and children are not applicable.
"	Authorization and Acknowledgement	"I/we", "my/our" and "(and my spouse and/or my dependents, if they are to be insured)"	Bracketed so the references to spouse and children may be deleted if evidence of insurability for spouse and children are not applicable.
"	Signatures	Signatures for Spouse and children	Bracketed so the spouse and children signature items may be deleted if evidence of insurability for spouse and children are not applicable.

STATEMENT OF VARIABLES
G-23223

FORM NUMBER	SECTION TITLE	PROVISION/ DESCRIPTION	BRACKETED VARIABLES EXPLANATION
G-23223	Application for Life Insurance	Company address/phone number	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
"		OneAmerica (logo)	Bracketed for ease in updating the logo in case it is changed.
"	"	Group Name and Group Number	Bracketed to allow Group Name and Group Number to be included or deleted.
"	#2 Proposed Insured's Beneficiary for the [Legacy Whole Life Insurance]	Whole Life Insurance	Bracketed for ease in updating as need arises whenever there is a change in product(s) offered – the change could be in a product name or it could be a new product that has been filed and approved by the state
"	#3 Insurance on Proposed Insured	Benefits	Bracketed for ease in updating as need arises whenever there is a change in products offered – the change could be in a product name or number or it could be a new product that has been filed and approved by the state
"	"	Fraud Notice	Bracketed to allow state variations of fraud language as necessary, per state law. State specific language is supplied by the individual states.